Community Report Card 2009

A Report of Clark County's Progress Toward Creating A Healthy, Livable Community

Community Choices

Listen ◆ Engage ◆ Mobilize

Columbian Waterfront

About Community Choices

History

In 1993, the Southwest Washington Health District (now Clark County Public Health) commissioned a study to assess the overall well-being of the people of Clark County, Washington. This year-long assessment examined the interrelated and multidimensional components affecting the health of the community.

The findings signaled some troubling health trends that mobilized Clark County residents to develop a plan of action. Their goal: to look 20 years into the future and envision the type of community Clark County had the potential to become. Community Choices 2010 was created to help the community take the necessary steps to achieve that vision and published the first Community Report Card in 1996.

In addition to producing a community report card every three years, the organization engaged partners and undertook specific projects that would lead to better community health. The hallmark project embarked on was Steps to a Healthier Clark County, a CDC funded program which focused on increasing physical activity and enhancing nutrition. Because of community participation and collaboration it was an outstanding success from which many other community projects were born. In 2008, realizing that there was work still to be done to create a healthy Clark County, "2010" was eliminated from the name. A tag line was added that would serve to communicate what we do: Listen, Engage, Mobilize.

Our Aspirations for Clark County

- We are a community that strives for a balance of economic vitality, personal health, social well-being, and belonging.
- We are a strong community that supports people of all ages, racial and ethnic groups, cultures, religions, gender, socio-economic status, abilities and lifestyles, and we recognize that social equity is a central component in achieving a sustainable community.
- We are a community that works together to respond to those in need for the betterment of the community as a whole.

Our Newest Initiative

In an effort to realize our aspirations for a healthy community, we are leading a new initiative that engages communities in the issue of health equity. Through our evaluation of data we have listened, through this report we endeavor to engage you in the issues that we face, and together we can mobilize to make Clark County one of the healthiest communities in the country.

Community Choices

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Table of Contents

Section 1
Determinant of Interest: Economic Vitality, Employment and Income page 5

Section 2
Determinant of Interest: Education page 7

Section 3
Determinant of Interest: Active Transportation/ Transportation Options page 10

Section 4
Determinant of Interest: Environment page 13

Section 5
Determinant of Interest: Accessibility of Food page 15

Section 6
Determinant of Interest: Social Environment: Connectedness and Exclusion page 18

Lauding Success and Pressing Forward page 21

Appendix A
Clark County Data on Selected Health Indicators page 25

Appendix B
Clark County Transportation Data page 29

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Vancouver's Farmer's Market

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The 2009 Report Card

Since publication of the first Report Card in 1996, Community Choices has been telling the story about the health of Clark County. Much of this has been done by reporting on disease, illness, injury and associated risk factors. This report takes an approach that will more quickly advance and sustain the health of our community and all of its residents.

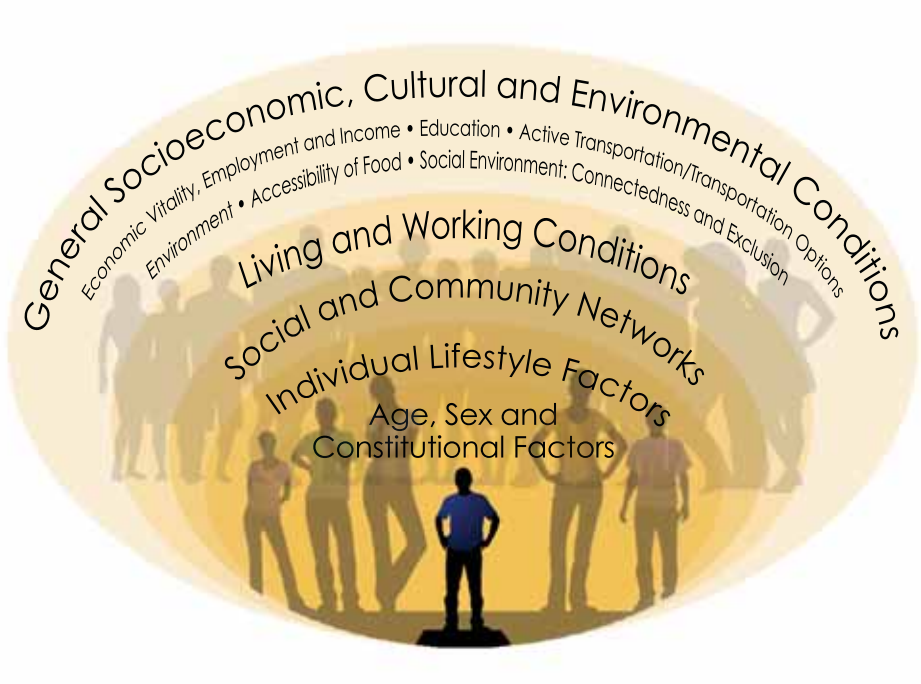
What makes this Report Card different?

In this Report Card we propose a new lens for examining the health of our county. It is time to zoom out to examine another layer to what constitutes health. These are factors that have an obvious or not-so-obvious influence on how healthy we are as a community, that eventually influence how healthy we are as individuals. Scientific research indicates that often this is a more powerful approach to creating a healthy community than focusing on individual behavior change, even though behavior change is critical to our health as well.[1] This Report Card addresses our collective health and, as part of this approach, the factors evaluated are social determinants.

What are the social determinants of health?

Taking the view that health, as defined by the World Health Organization, "is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"[2] we understand that what determines our health reaches far beyond medical care. The broader impact is from conditions in which we live, from birth to old age, that are determined by social and economic policies. These conditions determine our ability to be healthy, such as access to healthy food, access to education, access to transportation, a non-toxic and safe environment, an ability to be socially involved, the ability to be employed, etc. These are largely determined by the priorities a community sets and are mostly responsible for health inequities – the avoidable differences in health between individuals within a community.[3]

One may ask how social determinants ultimately impact health status. Take the health issue of obesity for example. A person may be obese for several reasons: lack of physical exercise, eating unhealthy foods, using food as a means of coping with stress, etc. While individuals have personal responsibility to employ preventive or remedial measures to deal with unhealthy weight, the choices individuals make are



influenced by the choices individuals have. A person is limited in choice of physical activity if they do not have a safe neighborhood, nearby park for walking or enough money to get to a gym. Or if people do not have access to a supermarket that carries fresh fruits and vegetables, they may depend on getting less healthy foods from mini-marts or fast food restaurants that are easier to get to. These are just a few examples of how social structures impact healthy weight.

Instead of reporting on the status on the health of individuals in this county, this Report Card will focus on the outer circle - those determinants that are based on social, ecological and economic factors - and report on the data we have that reflect those. As we examine the data, it is important that we not only look at how the county as a whole is doing, but also examine the data for various sub-parts of our county to tell the story of health equity among our neighborhoods.

What is health equity?

Our ability to be healthy is not only affected by our knowledge of healthy behaviors and our motivation to change, but also by our opportunities to take advantage of healthy behaviors. Research shows that the more access the entire community has to health opportunities, the better the health of the individual members in that community. [4]

How can this Report Card make a difference?

Once we take a look at our assets and honestly appraise the areas in which we need to make improvements, we can take action to strengthen our community. We can take action both as individuals and as a collective.

As this Report Card goes to print, a severe recession is greatly impacting our community and the nation as a whole. Many of the impacts are not yet reflected in the available data. For example, as of October 2009, the unemployment rate for Clark County was 13.7 % (not seasonally adjusted) – notably the highest unemployment rate in Washington. In addition, city, county, and state governments, as well as non-profit organizations and private sector businesses, are experiencing budget shortfalls not seen in most of our lifetimes. This is resulting in a loss of public services, safety net services, and jobs that are sure to impact our communities, our residents, and ultimately, everyone's health.

This Report Card examines six social determinants of health based on the data we have available. For each determinant, we indicate steps that will improve our indicators and thus our community's health in the years ahead. We hope that the information we present in this report will cause our county to become the healthiest community in a state striving to be the healthiest in the nation.

Section 1 Determinant of Interest: Economic Vitality, Employment and Income

Research indicates that economic conditions impact health throughout one's life. Those who have adequate or high incomes have better health than those that don't. [5] The effects of economic strain are cumulative and severe resulting in a stress that impacts physical health often resulting in illness.[6]

In the World Health Organization's publication The Solid Facts[7], examples of economic stress include having limited family assets, being unemployed, having insecure employment, having employment with low job control and no growth potential, living in poor or insecure housing, and being burdened by debt. In addition to the impact of not having material resources, the social difference caused by relative disadvantage, that is, feeling like you have less than most of the population around you, causes further psychosocial stress.[8]

Wealth influences health because it provides access to other factors related to good health status such as education, food and social respect, as well as access to services such as prenatal and postnatal care. Self reported health status is a good indicator of an individual's health. A significant finding in a national survey is that health status improves with higher income and more education.

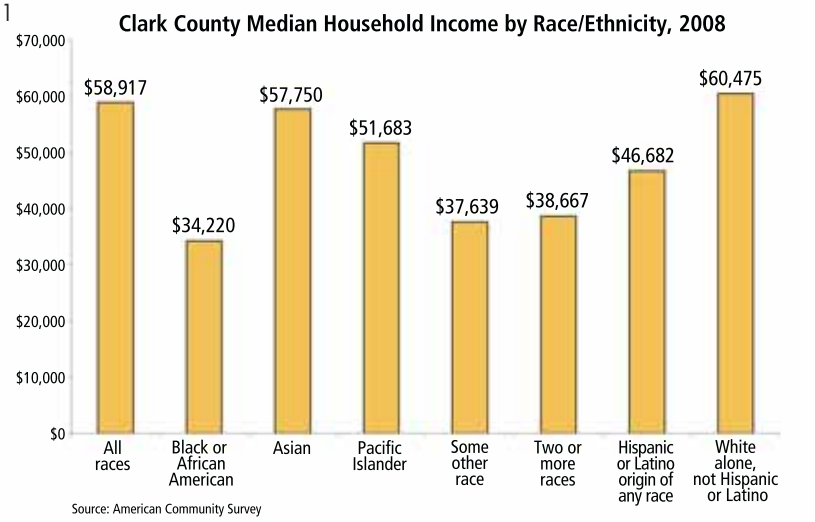
Here are some selected health effects that relate to this social determinant:

- Unemployed individuals have a higher risk of premature death.[9]
- Job insecurity affects mental health, heart disease and the risk factors for heart disease.[10]
- Absenteeism due to sickness, low back pain and cardiovascular disease are associated with low control over one's work.[11]
- Life expectancy is found to be connected to one's class which is linked to income.[12]
- Poor children are 15% less likely to be in good health than their wealthier counterparts. The difference grows to 19% in teen years.[13]
- Low income women are more likely than their wealthier counterparts to have low birth weight babies. Low birth weight is associated with a myriad of poor health conditions that are both physical and mental.[14]

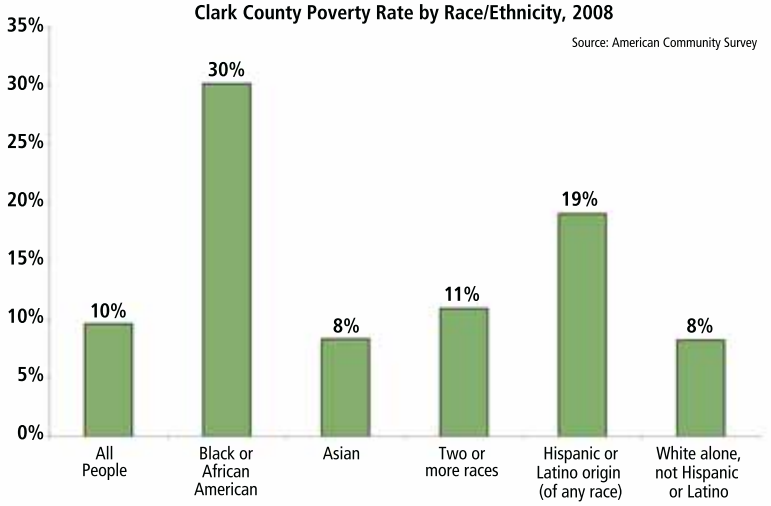
The Local Picture

The data in graph 1.1 indicate that in Clark County the median income is almost $60,000 which surpasses that of the national median (in 2008 the national median income was $52,029). This is very positive. However, the data raise major concerns about equity. African American and Hispanic households earn significantly less than other races.

Graph 1.1

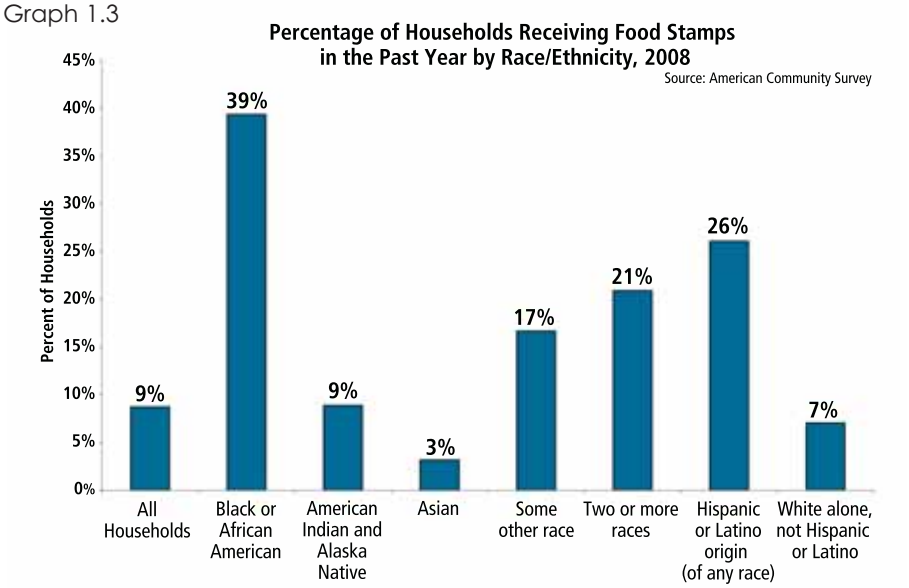


Graph 1.2 shows that poverty disproportionately affects those same groups.

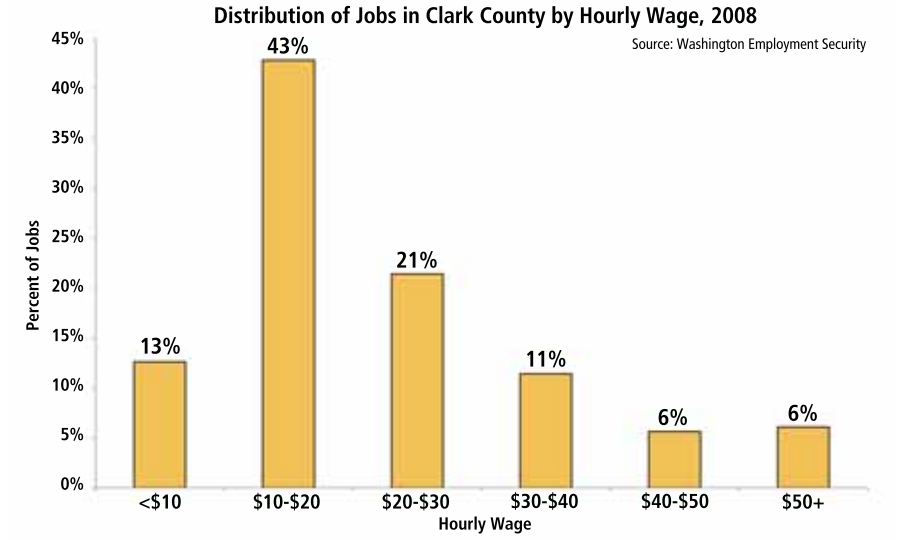


Graph 1.3 is troubling; almost 40% of the African American population in our county has received food stamps in the past year. The job distribution graph (graph 1.4) shows that more than 40% of the jobs in our county pay between $10-20 per hour and more than 10% of our workforce is in low wage jobs. This reflects income differences in our community that could impact health. Data on the self reported health status of our community are shown in Appendix A and matches the national data: those with better incomes and more education report better health.

Graph 1.3



Graph 1.4



What we can do about it

Individuals

- Support local industry by buying locally produced goods as a means to see dollars and jobs stay in the community.
- As an employer, develop a corporate culture of participation and individual decision-making; the payoff will likely be lower absenteeism, higher morale and higher productivity.
- Engage in thoughtful budgeting and debt management for your household.
- Youth must gain employable skills through local resources such as the Southwest Washington Workforce Development Council (SWWDC); if you are a working adult become a SWWDC volunteer or partner.

Community

- Advocate for economic expansion through the Columbia River Economic Development Council and the local chambers of commerce.
- Create and participate in free community events such as concerts, lectures or social gatherings, that minimize income differences and promote equity.

Policy Makers

Create policies that

- Ensure affordable housing. Fund Tenant-based Rental Assistance. [15]
- Encourage local business development and job creation.
- Prevent poor lending practices.
- Fund programs in schools and colleges that provide skill training for middle-wage jobs; specifically support the Science, Technology, Engineering and Math (STEM) program because of the demand for associated jobs created in our region.
- Implement a buy local campaign (to support local businesses and to assure the capture of tax revenue to fund public services).

Section 2 Determinant of Interest: Education

Education is the most powerful social determinant of health because it helps ensure access to employment and social mobility.[16] The previous section identified the impact of employment and socioeconomic status on health.

National research shows that educational attainment is generally disproportionate across races and classes, with the gaps in achievement beginning in early childhood and persisting throughout the educational experience. Special early learning programs like Headstart and Early Childhood Education and Assistance Program (ECEAP) are designed to give all children an equal opportunity for success and reduce learning differences at an early stage of the process.[17]

In addition to the impact of education itself on health because of its relationship to economic success, research indicates that schools provide access to health knowledge and tools that assist in acquiring help and resources, such as smoking cessation programs. Educational institutions teach skills that foster social involvement and the ability to cope with social factors that lead to stress[18] which affects the ability to access social resources (see section six for more on this topic). Essentially, education helps people gain a sense of control over their lives which is a factor involved in good health.

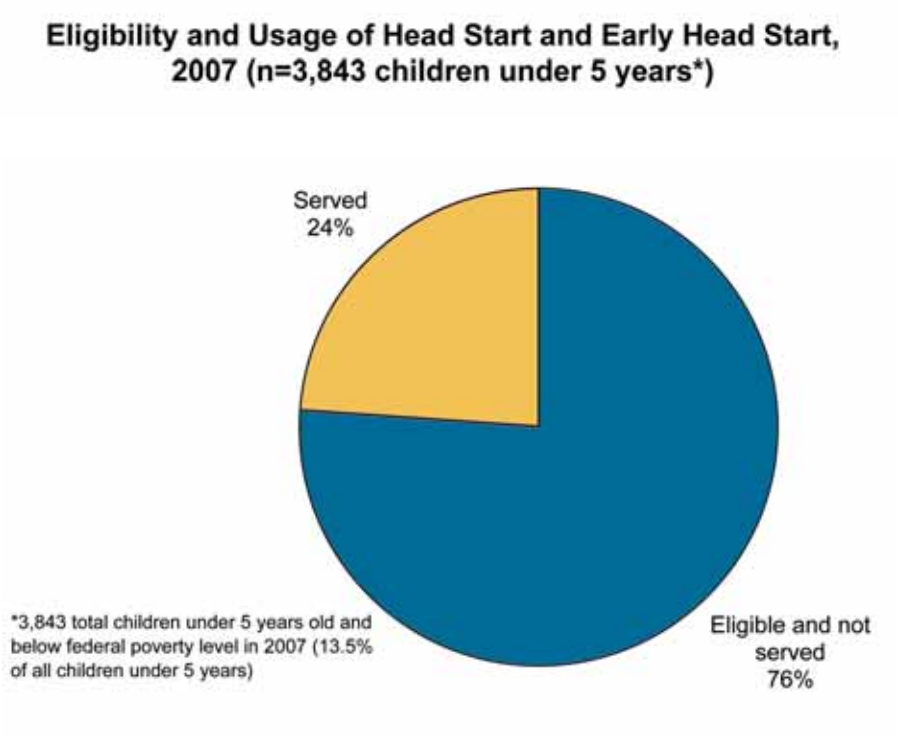
Here is what we know about selected health impacts of education:

- Low education correlates with higher risky health behaviors like smoking, being overweight and having low physical activity.[19]
- Lower educational attainment and household income are consistently related to greater disease severity, poorer lung function, and greater physical functional limitations in individuals with chronic obstructive pulmonary disease.[20]
- Adult educational attainment associated with income and social status is negatively correlated with cardiovascular health and metabolic syndrome (metabolic syndrome leads to diabetes)[21]

The Local Picture

Headstart data reveal that there are low-income children who are unable to access the early education they need due to lack of funding. See graph 2.1

Graph 2.1

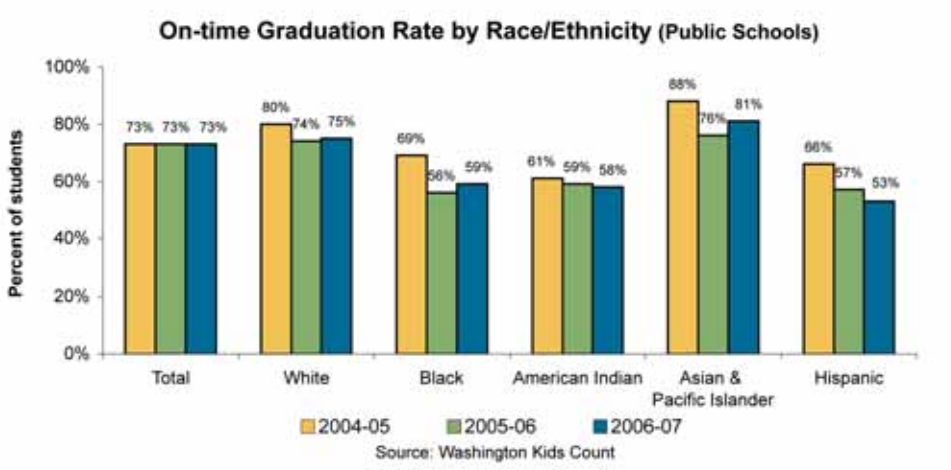


Source: Educational Opportunities for Children and Families

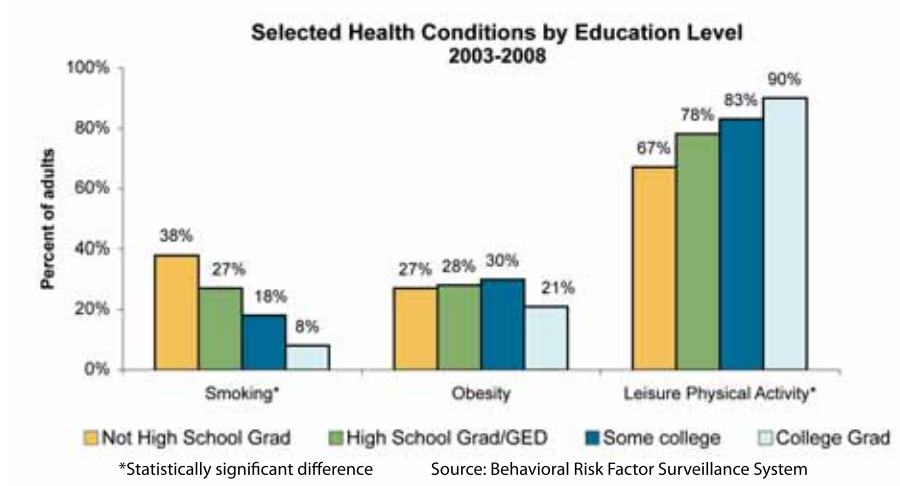
Research indicates that those from low income backgrounds who are unable to access early learning programs lag behind their peers when they enter school. Locally this is evident in graduation rates. See graph 2.2 and 2.3.

We also see the impact on health behavior and on earning potential. See graph 2.4 and 2.5.

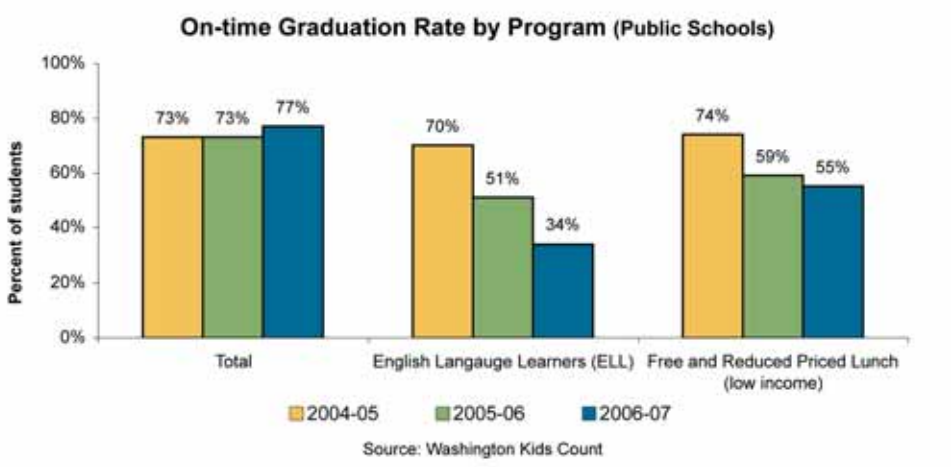
Graph 2.2



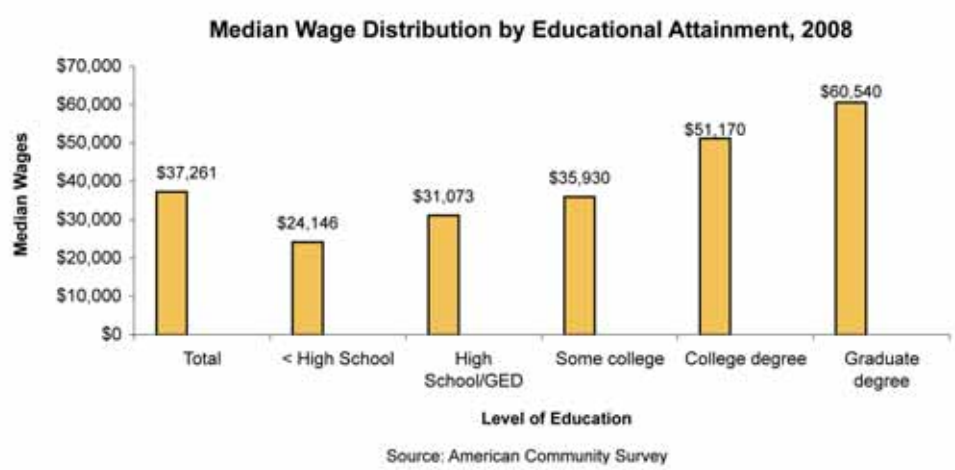
Graph 2.4



Graph 2.3



Graph 2.5



What we can do about it

Individuals

- Devote time and energy to get involved with youth through mentoring or participating in youth-focused activities (research shows that the more connected youth are to caring adults, the less likely they will be to drop out of school).
- Create and donate to scholarships that facilitate access to post secondary education.
- Contribute time and money to help high schools acquire the necessary resources and programs that will ensure equitable graduation rates.
- Volunteer at a local Family Resource Center to provide mentoring and support to those who take care of the social and emotional needs of elementary school children and their families.
- Access resources at local community colleges and universities to help reduce financial and knowledge barriers to acquiring an education.

Community

- Advocate for accessible educational opportunities for all community members both at the K-12 level as well as higher education.
- Create and participate in drop-out prevention councils.

Policy Makers

Create policies that

- Increase funding of early education programs such as Headstart and ECEAP (this will mean urging state and federal legislators to prioritize this funding in their respective budgets).
- Adequately fund mandates that require school improvement and increased student achievement.
- Ensure that health and mental professionals are available at all our educational institutions.
- Prioritize prevention of high school drop out rates by placing it on the public health agenda.

At ESD 112, our mission is to serve children, schools and their communities. This means ALL children, schools and communities, regardless of size, location, or unique needs. Our programs serve the earliest learners, from birth up through high school graduation and beyond.

We partner with school districts and a wide variety of community agencies in the areas of early learning, special education, transportation, student data management, school construction, staff training, student improvement, prevention intervention and more. Our goal is to assure equity and opportunity for all children.

Section 3 Determinant of Interest: Active Transportation/Transportation Options

Transportation is a critical aspect of our communal and individual lives. There is ample research on the connection between transportation and health. The direct effects are:

- air quality
- risk of injury
- level of physical activity, and
- access to essential goods such as grocery stores

Active transportation such as walking, biking and taking public transportation is a benefit to health. Healthy communities invest in sidewalks, trails and bike lanes, and public transportation routes that have destinations related to our activities of daily living. These connect us to getting to work, school and our places of worship; getting to services such as grocery stores, barber shops, drug stores, and the library; and getting us to interesting places where we recreate, socialize and take in the beauty of our community.

International statistics indicate that obesity rates are correlated to hours spent in cars.[22] Accessible public transportation often affords a higher degree of physical activity and additionally has environmental and economic benefits. An additional direct impact relates to injuries. Poorly planned pedestrian, bike and motor vehicle routes also result in severe and fatal injuries that can be prevented by planning for multi-modal transportation routes.

According to Angela Glover Blackwell of PolicyLink, "Transportation is also one of the largest drivers of land use patterns; it thus determines whether communities have sidewalks and areas to play and be physically active as well as whether communities are connected to or isolated from economic and social opportunities."[23] Indirectly transportation impacts health by way of income and educational opportunity since transportation options are necessary for reliable and efficient means of getting to jobs or to schools and colleges. It is also necessary for access to medical care and impacts whether regular and preventive care can be sought.

While the impact of transportation on health affects all members of society, research shows that low-income communities and communities of color are disproportionately impacted by issues such as fewer access points to public transportation and lack of safe pedestrian and bicycle pathways including trails.

Nationally, issues surrounding transportation are recognized and reform is on the way. James Oberstar, Chairman of the House Transportation and Infrastructure Committee wrote, "With a greater recognition of the strong linkage between public health and transportation, I believe we can build a network that supports our mobility and creates access and economic strength while promoting equity, sustaining our good health and quality of life."[24]

The Local Picture

Given the direction of the national agenda regarding transportation, it is timely to look at our community with regard to transportation. Here is the data we have about growth in transit ridership compared to vehicle miles traveled. See chart 3.1

Chart 3.1

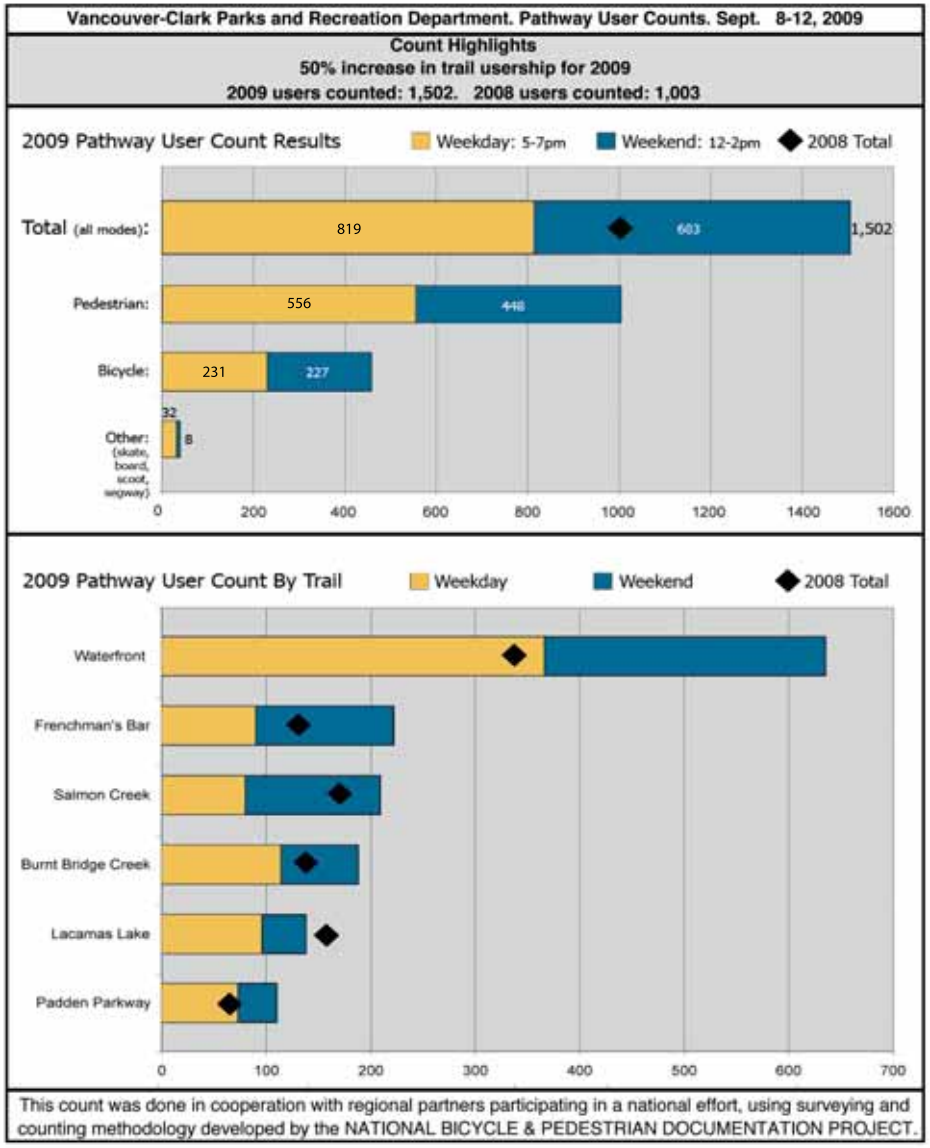
Clark County Vehicle Miles Traveled and C-Tran Boardings

Year	Clark County Population	Clark County Population 5-Year % Increase or Decrease	Clark County Annual Vehicle Miles Traveled (in thousands)	Clark County Annual VMT 5-Year % Increase or Decrease	Clark County Annual Vehicle Miles Traveled per Capita (in thousands)	Clark County VMT per Capita 5-Year % Increase or Decrease	Annual C-TRAN Boardings (fixed route service)	Annual C-TRAN Boardings 5-Year % Increase or Decrease
1990	238,053		2,083,440		8,752.00		2,777,383	
1995	291,000	22.2%	2,231,837	7.1%	7,669.54	-12.4%	5,153,190	85.5%
2000	345,000	18.6%	2,625,650	17.6%	7,610.58	-0.8%	6,564,961	27.4%
2005	391,500	13.5%	2,747,776	4.7%	7,018.58	-7.8%	5,614,951	-14.5%

Data Sources: SW WA Regional Transportation Council

We also have data on the pedestrian and bicycle use of our county trails. See graph 3.2

Graph 3.2



The data reveal that we are increasing our use of cars and decreasing our transit use which is moving in the wrong direction for our health and our environment. The good news is that our use of trails for walking and biking has increased significantly. We need to note, however, that in a survey of those using trails, the primary means of accessing them was by car.

Additional data on the modes of transportation used for commuting can be found in Appendix B. In the future it will benefit us to collect other pieces of information that can tell us more about the equity of transportation options in our community like location of bus stops and the frequency of bus connections, etc. It will also be beneficial for us to collect information on the accessibility of transportation options.

C-Tran 99th Street Transit Center

What we can do about it

Individuals

- Make a personal commitment to take advantage of active transportation options.
- If you are an employer, provide incentives for reducing vehicle usage and improving health.
- Be an advocate for everyone in the community to have access to reliable transportation options.
- Support the county Parks and Recreation department to create and maintain trails.

Community

- Engage in advocacy groups such as the Friends of Clark County and Community Choices.
- Mobilize your neighborhood association to advocate for walking paths and trails in your neighborhood.
- Develop neighborhood momentum around safe routes to schools and innovative programs like the "walking school bus" that has multiple benefits such as improved attendance, healthy child-adult alliances and improved health.
- Implement "Point of Decision" prompts encouraging people to take the stairs. [25]
- Develop neighborhood walking partnerships that increase accountability to active transportation.
- Develop neighborhood maps that show walking routes to parks, points of interest, trails, and local services.

Policy Makers

Create policies that

- Promote transit oriented residential neighborhoods and multi use districts.
- Fund the Trails and Bikeway Systems Plan.
- Fund projects that implement way-finding signage to trails, parks, and other neighborhood points of interest.
- Implement Community-scale Urban Design Land Use Policies & Practices. [26]
- Implement Street-scale Urban Design Land Use Policies & Practices. [27]
- Promote building practices that engineer activity (such as making stairwells visible and inviting from the building entry and that give a sense of safety for the user).
- Insist that Health Impact Assessments (a combination of procedures, methods and tools by which a policy, program or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population) be conducted for all transportation planning including the Columbia River Crossing; select plans based on maximizing pedestrian and bike friendliness and safety.

Bike Lane in Vancouver

Section 4 Determinant of Interest: Environment

It is well established that all health is influenced by our social and physical environment. The social environment impact is multi-factorial and complex and will be discussed further in section six of this report. In this section we will examine the impact of our physical environment on our health and how it relates to the issue of equity.

To be healthy we would optimally live in a pollutant-free and toxin-free environment. Recognizing this is impossible, getting closer to the ideal is a healthy goal. Of particular concern is that some of us are more likely to be exposed to pollutants and toxins than others of us. For example, the literature finds that

- Low-income neighborhoods are often located near highways, thoroughfares and/or transit centers; air pollution associated with high traffic areas not only impacts general health and reduces the desire for outdoor activity, but correlates with a higher incidence of asthma. [28]
- Low income housing opportunities also tend to exist near industrial areas where there is a higher likelihood of chemical contamination in the soil or water. [29, 30]

Environmental characteristics of a neighborhood can also influence health by way of the presence or absence of forces that constrain physical activity.

- Easily accessible, safe and clean parks are an invitation to exercise especially if others around you utilize those spaces for exercise and healthy activities. [31]

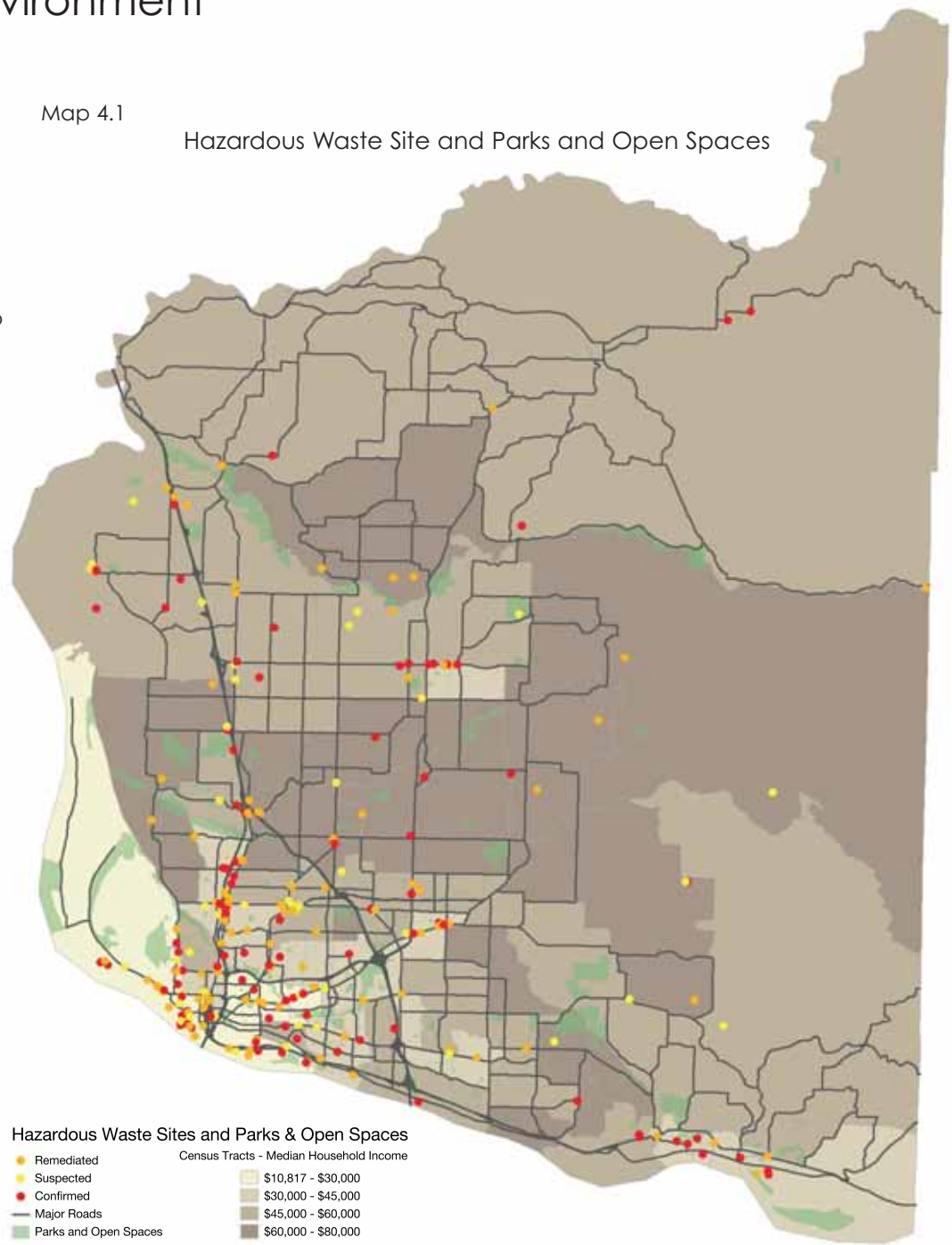
The Local Picture

While we would like to have neighborhood level air quality data, those data are not currently collected. We do, however, have data on the location of brownfields (contaminated/hazardous waste sites) and greenspace. The following map superimposes these data on the county income data county. See map 4.1

The map shows some greenspace even in some of the urban areas of our county which is positive. The map also reflects, however, that low-income neighborhoods tend to be limited in parks and also have disproportionately high numbers of sites of contamination. These areas tend to be more densely populated because of the affordability of housing and accessibility to public transportation.

Map 4.1

Hazardous Waste Site and Parks and Open Spaces



What we can do about it

Individuals

- Reduce consumption overall – this will reduce demand for solid waste facilities and reduce toxins in our air, food, and drinking water.
- Teach children about conservation.
- Recycle at home and work.
- Use cups/containers from home when buying take-out food.
- Drive less to reduce pollution.
- Utilize your neighborhood parks regularly and make a case for their existence.
- Stay informed about the location of both greenspaces and brownfields. Advocate for equity in the distribution of parks, trails and open spaces.

Community

- Be intentional about including environmental issues in neighborhood conversations.

Policy Makers

Create policies that

- Role model environmental stewardship through conservation and planning with sustainability as a priority.
- Implement policies promoting drinking of tap water versus bottled water (reduces recycling and landfill demand), reduces greenhouse gas emissions, and is less costly to consumer.
- Mandate regular physical environment audits at the neighborhood level to determine equity in the availability of greenspace. Clean up waste sites and convert brownfields to useable land.
- Fund home-based multi-trigger, multi-component environmental interventions aimed at children and adolescents with asthma. [32]

Lucia Falls Trail northern Clark County

Section 5 Determinant of Interest: Accessibility of Food

There is much evidence indicating a connection between neighborhoods and dietary habits, weight and chronic illness. One of the biggest correlations between health issues and neighborhoods is the accessibility of food.[33] Findings include

- Obesity and poor dietary habits are linked to the inaccessibility of supermarkets and to the high access to convenience stores.
- Low income and minority neighborhoods tend to have less access to supermarkets.[34]
- These neighborhoods are typically more dense with convenience stores and inexpensive fast food restaurants.[35]
- Not only is the distribution of supermarkets unequal, but the distribution of products between supermarkets is unequal. Healthy products available in high income neighborhood grocery stores are likely to be unavailable in grocery stores of lower income neighborhoods.[36, 37]
- Community gardens are currently under examination as a means to improve health in both low-income urban and low-income rural areas of food insecurity (food insecurity means that food is not readily available due to finances or physical accessibility).[38, 39]
- Improved health is a result of increased consumption of fruits and vegetables, as well as from physical activity.[40]
- Community gardens have the additional health benefits that arise from increased social connectedness.[41]
- Strengthening and supporting the local food system is an important component of improving access to healthy food. "A locally oriented regional agricultural system is an important ingredient in the quality of life formula."[42]

The Local Picture

Clark County data regarding location of supermarkets and convenience stores is shown in map 5.1.

This map reveals that our community is consistent with the literature, that is, supermarkets are less prolific and convenience stores more prolific in low income neighborhoods. What is unknown is whether there is a difference in healthy food availability in supermarkets that are in low income vs. high income neighborhoods.

Map 5.1

Community garden programs take many forms and are supported by a wide array of community partners including schools, neighborhoods, parks and recreation, social service agencies, emergency food programs and churches. See table 5.2

Table 5.2

Clark County Gardens (total of 87)

Neighborhood	Total #	Public	Youth	Home Garden Projects Individual	Other
Bagley Downs	1				1
Battle Ground	1		1		
Camas	3		3		
Cascade	1			1	
Central Park	6	1	2	1	2
Clark County - unincorporated	1			1	
Countryside Woods	2			2	
East Minnehaha	1			1	
Ellsworth Springs	1	1			
Fairgrounds	2	1			1
Fircrest	1		1		
Fisher-Mill Plain	1		1		
Fisher's Landing East	1				1
Fourth Plain Village	2			2	
Fruit Valley	3	1	1	1	
Greater Brush Prairie	1		1		
Harney Heights	3			3	
Hough	1			1	
Hudsons Bay	4	2		1	1
Image	2		1	1	
Maple Tree	1				1
Marrion	1			1	
Meadow Homes	3	1	1		1
N Image	2		1	1	
NE Hazel Dell	5	1	2	1	1
Northwood	1			1	
Ogden	1				1
Orchards	1		1		
Ridgefield	1				1
Rose Village	21		1	18	2
Shumway	1				1
Sunnyside	2			2	
Truman	1			1	
Vancouver Heights	2	1		1	
Washougal	2	1	1		
Washougal River	1		1		
West Hazel Dell	2			1	1
West Minnehaha	1			1	

Note: "Other" includes gardens for businesses, specific populations, and faith-based organizations Source: Clark County Public Health

Clark County is experiencing an increase in community interest and support for ensuring residents have the resources, tools and knowledge to grow food locally for themselves and for donating to others. The Clark County Homegrown Garden project, launched by Clark County Public Health, is one example of a local program working to decrease food insecurity and increase fruit and vegetable consumption for those most at risk. Our goal is to increase and support community garden programs through community partnerships that work to reduce food insecurity and increase access to healthy food.

Data collected on initial efforts of the Homegrown Garden Project indicate that 50 % of those participating in the Homegrown Garden Project increased their fruit and vegetable consumption and 25 % had increased their physical activity. To get a picture of the overall fruit and vegetable consumption in Clark County please refer to Appendix A.

The benefits of buying locally grown food are many for the consumer the community and the environment. However families with limited food resources that participate in the Supplemental Nutrition Assistance Program (SNAP) have not been able to use their food benefits to buy produce from local farmers. Three area markets began accepting SNAP benefits in 2009, adding to programs already provided through the Women, Infant and Children (WIC) and Senior Farmer market programs. With a 31% increase in SNAP participants in Clark County since February of 2008, these farmers' market programs are an important component of equitable access to healthy food. Given that only 9% of dollars spent on food are spent for food produced locally, increasing the amount of dollars spent for locally produced foods will assure improvements in access to healthy food while strengthening the local economy and help preserve farms and farmland.

What we can do about it

Individuals

- Increase your personal fruit and vegetable consumption – and create a market demand for healthy foods produced in your area.
- Grow your own food, support a community garden program or become a garden mentor.

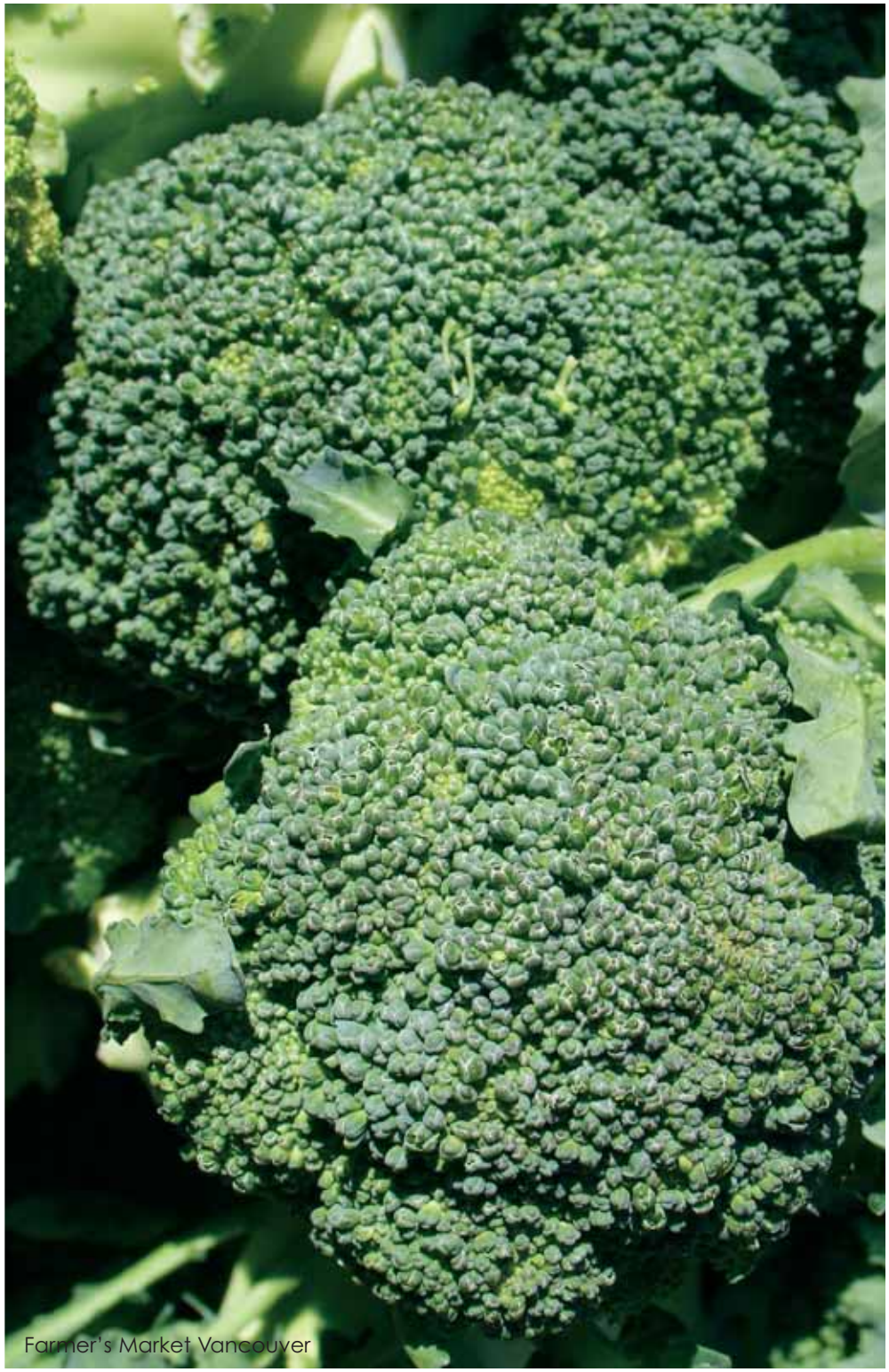
Community

- Advocate for healthy and affordable food access at the neighborhood level.
- Support accessibility to community garden programs.
- Develop public and private partnerships for community education on healthy food production and preparation.
- Work with public and private organizations to develop transportation systems which improve access to healthy food.
- Support Clark County Food System Council; working to increase and preserve access to safe, local and healthy food.

Policy Makers

Create policies that

- Link public transportation options with grocery, farmers markets, food banks and other sources of healthy, affordable food.
- Develop policies related to buying more locally produced food.
- Ensure equitable availability of healthy food by providing incentives for retailers to locate in and/or offer healthier choices in underserved areas.
- Ensure food system elements are incorporated into community planning processes.
- Inform restaurant customers of calorie and nutritional content of menu items.
- Fund and support community gardens, community sustained agriculture (CSAs).
- Support land use policies that preserve agriculture lands, encourage urban "farming"—gardening and raising of livestock appropriate in urban settings.



Farmer's Market Vancouver

Section 6

Determinant of Interest: Social Environment: Connectedness and Exclusion

Our social environment plays a large role in health. Over the past decade research into the influence of social environment on health has been prolific.

Here are some specific ways a person's social situation can impact health:

- Our early childhood environment impacts our coping and socially acceptable behavior as adults. The connectedness between parent and child influences the development of empathy and ability to form healthy relationships.[43]
- Favorable psychosocial environments that include social support and networks, social capital, social cohesion, collective efficacy, participation in local organizations go hand in hand with better health.[44]
- In studying women living in disadvantaged neighborhoods it was found that strong social networks helped alleviate factors leading to poor health.[45]
- Social disadvantage and social exclusion or discrimination leads to social stress which has health implications as discussed in the first section of this report. Research indicates that social inequality can result in illness.[46, 47]
- Childhood health predicts adult social mobility[48] which indicates that our efforts to ensure adult equity begin with caring for child health.

Groups often facing discrimination are

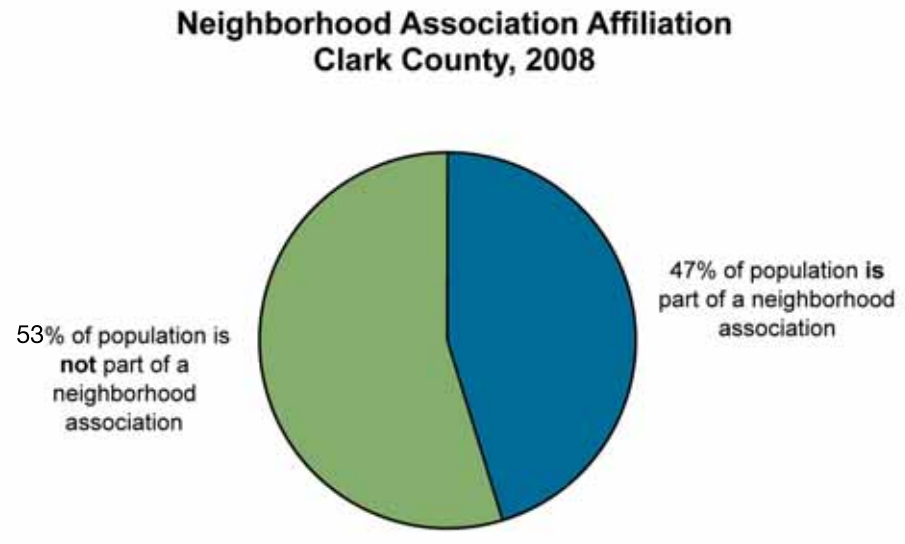
- minority populations
- low income populations
- mentally ill populations
- homeless populations
- sexual minority populations such as the gay, lesbian and transgendered communities
- religious minorities
- disabled populations

The Local Picture

It is not easy to locate data about community connectedness, social exclusion and discrimination in Clark County.

However, we do have some information regarding whether people have opportunities for connecting with each other and having a conduit for their voice in the community. Neighborhood associations exist as a means to organize and advocate around issues that impact one's neighborhood, as well as organize activities for the community. They are also a mechanism for getting information out to the community. Clark County has an impressive 30 neighborhood associations. The graph below indicates how much of our population has opportunity for affiliation to a neighborhood group. See graph 6.1

Graph 6.1



Source: Clark County Neighborhood Outreach

We also have some information on homelessness from which we can infer that there are individuals who can't really participate in the greater workings of society because they do not have an address. The homelessness in our community also reflects the lack of affordable housing in our community and/or the employment situation in our community. See table 6.2.

Table 6.2

One-Day Homeless Count

The Council for the Homeless conducts a county-wide "one-day homeless count" once each year as required by both the U.S. Dept. of Housing and Urban Development (HUD) and by Washington state law. Volunteers and outreach workers visit shelters, service providers and other locations where people who are homeless may congregate in order to take a statistical and demographic snapshot of homelessness in Clark County.

The chart below reflects statistics compiled on January 30, 2009, as reported to HUD and must be considered in the context of a one-day "point in time" count by volunteers and staff at 19 "unsheltered" sites, 12 "sheltered" sites and 24 transitional housing locations. The next count is scheduled for January, 2010. Statistics from that count should be available in April of 2010.

ONE-DAY POINT-IN-TIME COUNT - JANUARY 30, 2009

Part 1- Homeless Population	Sheltered		Unsheltered	Total
	Emergency	Transitional		
1. Number of Family Households with Dependent Children	67	137	30	234
1a. Number of Persons in Family Households with Dependent Children (Adults & Kids)	201	331	90	622
2. Number of Households without Dependent Children	135	243	112	490
2a. Number of Single Individuals and Persons in Households without Dependent Children	148	247	142	537
Total Persons (Add 1a and 2a)	349	578	232	1159
Part 2-Homeless Subpopulations (Adults only, except "g." below)				
a. Chronically Homeless	71	65	22	158
b. Mentally Disabled	51	45	18	114
c. Persons w/alcohol and/or drug problems	41	42	16	99
d. Veterans	27	25	4	56
e. Persons w/ HIV/AIDS	-	6	-	6
f. Victims of Domestic Violence	48	76	4	128
g. Unaccompanied Youth (Under 18)	13	13	30	56

Source: Council for the Homeless

The data show that there is a healthy percentage of our population that cares about what happens in our community. According to the Neighborhood Outreach Program coordinator, Clark County's neighborhood association collaboration stands out nationally because individual associations are active, informed, engaged and networked with each other; they also have a strong partnership with the County. This is good news.

Unfortunately the statistics we have on homelessness indicate that there are many individuals in our community who are not participating in it because they do not have a place of residence. An even sadder implication is that there are many people in our community whose basic human needs are going unmet. The heavy representation of mentally ill in the homeless population of our community indicates that we have much more to do in the area of psychiatric and psychological intervention.

We lack explicit data regarding the degree of minority engagement that exists in our community. Ideally, diverse individuals are able to participate in policy making by providing citizen input. In order for that to happen opportunities for community participation in public affairs (such as townhalls, forums and public comment periods) must occur by disseminating information through avenues that marginalized populations are most likely to connect with as well as holding meetings at times and places that are accessible to those who are working at jobs with little flexibility for daytime participation.

What we can do about it

Individuals

- Engage in self reflection to identify your own biases.
- If you are part of a religious organization, get involved in the organization's social justice mission (most faiths recognize the primacy of this effort to spirituality…and if your organization does not have one, start one!)
- Volunteer in schools, community programs or non-profit organizations.
- Educate yourself on the experiences of those in your community who suffer discrimination; advocate on their behalf.

Community

- Build coalitions.
- Invite everyone to be part of community activities by being intentional about issues of access at the onset of planning.
- Create an environment that attracts diverse individuals into our community; be intentional about letting their voices be heard in public venues.
- Create book clubs, knitting clubs, sports clubs, etc that will enhance our connectedness and reduce isolation.

Policy Makers

Create policies that

- Fund proven intervention programs developing parenting skills and parent-child bonding from conception through age five. [49]
- Ensure equal rights for all.
- Prevent homelessness by ensuring affordable housing and availability of prompt psychiatric intervention.
- Fight for funding adequate mental health services in the community.
- Ensure the representation of minority and low-income groups in policy meetings and community conversations; be intentional about your outreach and timing.
- Implement Comprehensive, Center-based Programs for Low Income Children. [50]
- Fund Collaborative Care Programs for the Management of Depression and Depressive Symptoms for those 18 years of age and older. [51]
- Fund Home-based and Clinic-Based Depression Care Management Programs for older adults.[52]
- Encourage development practices that foster community and social connectedness.

Alternative Transportation — Parking Day

Section 7 Lauding Success and Pressing Forward

Success in Collaboration

Comprehensive efforts that must be made to address social determinants of health are often viewed as daunting. It is important to recognize that work is already underway in many of Clark County neighborhoods. A snapshot of a successful effort will provide not only inspiration, but a template for collaboration that improves health. The Fruit Valley neighborhood is an impressive example of community commitment to health and equity.

The Neighborhood

Fruit Valley is the largest neighborhood by area in the city of Vancouver. It is located on the Western side of the county and consists of residential areas, industry, business, agriculture and natural areas. This neighborhood of approximately 1000 households is seeing a surge in vitality as the community has rallied to overcome the effects of economic and environmental strain.

The Health Concerns Faced

In Fruit Valley 52% of families with children live in poverty. The average household income is $25,000 per year. Eighty-four percent of the students from this neighborhood qualify for free and reduced lunch. In 1998 the groundwater was found to be contaminated with trichloroethylene.

The Collaborators

Several community members, organizations and partners mobilized in the effort to improve economic support, access to food, environmental improvement, educational attainment and community connectedness. Three organizations exemplify the connecting of efforts to improve neighborhood conditions:

The Fruit Valley Family Resource Center (FVFRC) at the Fruit Valley Elementary School - With the goal of supporting children to become successful adults through meeting the needs of their families and connecting them to caring adults, this resource center has become a significant part of community life in Fruit Valley. FVFRC is a place where children feel valued and adults find opportunities for self improvement. In addition to housing a child care consortium, food bank and clothing closet, it also is a community gathering venue and a place where children and families can access mental health and social service support. A community computer lab enables job searches as well as access to other information and resources that community members need.

The Fruit Valley Foundation (FVF) – Established to address the human welfare needs in this neighborhood, the FVF provides human and material resources to help residents maximize their potential. The foundation supports the FVFRC in addition to providing grants for home improvements. Two other notable programs administered by the foundation are Students Transitioning into Exceptional People (STEP) which provides mentoring to 250 students a year who are entering middle school, and Ladies of the Valley which is a support network for women. The foundation is also leading a movement called The Future Initiative which is based on mapping the community's assets and then building programs and partnerships around those assets to improve the life of families.

The Fruit Valley Neighborhood Association – This association is a shining example of community engagement. Fueled by their motto "Working together, we make it happen!" this group of citizens has worked to enhance the social atmosphere of the community in addition to being advocates for environmental safety. They promote the FVFRC, FVF and the city's community garden program. Clean up of ground water contamination through the Port of Vancouver has been ensured through their advocacy. The community newsletter keeps neighbors informed not only of social events but also advocacy opportunities.

Evidence of Success

The greatest evidence of success in the Fruit Valley neighborhood is the partnerships that formed in a pure interest for community improvement. There have also been measureable improvements in student achievement. The school has developed a garden area that encourages healthy eating. Community garden plots in the park are also filled at 100% each year. An additional effort towards healthy eating and consumption of local produce is the Neighborhood Action Plan that calls for the establishment of a local farmer's market. In the area of active transportation, the neighborhood has succeeded in getting C-Tran to initiate a trial for a shopping bus that will give Fruit Valley residents access to an affordable food source. Environmental

success is apparent in the reduction of groundwater contamination. Partnerships with local businesses evidence the support for improvement of the economy as well.

Moving Forward for the Health of Our Community

The Fruit Valley neighborhood is not alone in improving health but it does serve as a good example of what is possible when a community unites to address the social factors that impact health. Through this report we have presented a shift in the traditional view of health and the pathways to achieving it. Hopefully the scientific evidence, local data and explanations have succeeded in demonstrating the benefit of taking a broader approach to improving health. We believe the practical recommendations for individual, community and policy change will serve as a guide to making us and our neighborhoods the healthiest they can be.

As Grace Budrys concludes her book on the contribution of inequality to health or illness, she acknowledges the challenge of making systemic change. She urges, "If no one takes the first step in advocating change, there will certainly be no change. If a few people begin to think that the potential benefits are certain to outweigh the difficulties involved in making changes, which admittedly will require a certain amount of sacrifice on our part, others might join in." [53] We encourage you to join Community Choices and a host of committed citizens and policy leaders in taking the next step to creating an even healthier Clark County.

Fruit Valley Family Resource Center

Notes

1. See, for example, Michael Marmot and Richard Wilkinson, eds., Social Determinants of Health (Oxford University Press, 2005).
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4. See, for example, Richard Wilkinson, Unhealthy Societies: The Afflictions of Inequality (New York: Routeledge Press, 1996).
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6. Nancy E. Adler and David H. Rehkopf, U.S. Disparities in Health: Descriptions, Causes, and Mechanisms, Annual Review of Public Health 29 (2008): 235.
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8. Gregory Miller and Edith Chen and Steve W Cole, Health Psychology: Developing Biologically Plausible Models Linking the Social World and Physical Health, Annual Review of Psychology 60 (2009): 501.
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11. Ibid., 18.
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20. Ibid., 1073.
21. Eric B. Loucks et al., "Socioeconomic Position and the Metabolic Syndrome in Early, Middle, and Late Life: Evidence from NHANES 1999-2002, Annals of Epidemiology 17 (2007): 782.
22. See, for example, Sustain (an interdisciplinary research group focused on problems related to technology, behavior and climate change), http://sustain.cs.washington.edu/blog/index.php/2009/01/16/the-relationship-between-cars-and-obesity/
23. Judith Bell and Larry Cohen, The Transportation Prescription: Bold Ideas for Healthy, Equitable Transportation Reform in America, ed. Shireen Malekafzali, www.preventioninstitute.org/documents/transportationRX_final.pdf: 8.
24. Ibid., 7.
25. CDC, The Community Guide, www.thecommunityguide.org/pa/environmental-policy/podp.html
26. Ibid,. www.thecommunityguide.org/pa/environmental-policy/communitypolicies.html
27. Ibid., www.thecommunityguide.org/pa/environmentalpolicy/streetscale.htm

28. Judith Bell and Larry Cohen, The Transportation Prescription: Bold Ideas for Healthy, Equitable Transportation Reform in America, ed. Shireen Malekafzali, www.preventioninstitute.org/documents/transportationRX_final.pdf

29. See, for example, Matthias Braubach and Jonas Savelsberg, Social Inequalities and their Influence on Housing Risk Factors and Health, www.euro.who.int/document/e92729.pdf

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50. Ibid., www.thecommunityguide.org/social/centerbasedprograms.html

51. Ibid., www.thecommunityguide.org/mentalhealth/collab-care.html

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53. Budrys, Unequal Health: 233.

Appendix A Clark County Data on Selected Health Indicators

Adult Health Conditions and Behaviors

	Health Conditions	Definition	County data: 2008 Rate	County data: 2008 Count	Healthy People 2010 Goal	Gender (%): Male	Gender (%): Female	Race/Ethnicity (%): White	Hispanic	Asian	Native Hawaiian /Pacific Islander	Black	Native American	Other
Health Status	Health Status	Self-reported health status	88	274,224	-	87	87	87	84	92	-	82	78	81
						No difference				Lower in Native American				
Health Access	Health Insurance	Health care coverage of any kind.	87	266,942	100%	86	89	89	65	92		82	87	57
						Males lower				Lower in Hispanic and Other				
	Could Not Afford Doctor	Could not afford to see a doctor when needed to because of cost.	13	38,663	-	12	14	12	27	-	-	-	-	-
						Males lower				Higher in Hispanic				
	Have Personal Doctor	Have one or more persons think of as personal doctor or health care provider	74	226,840	-	71	82	78	52	82		72	73	45
						Males lower				Lower in Hispanic and Other				
	Dental Visit [1]	Visited a dentist or dental clinic within the past year (for any reason)	72	222,882	56%	72	73	73	63	72	-	-	-	-
						No difference				Lower in Hispanic				
Substance Use	Smoking	Smoked at least 100 cigarettes in their life and now smoke every day or some days	17	51,810	12%	20	18	19	-	-	-	-	-	-
						Males higher		Racial/ethnic disparities could not be assessed due to small numbers						
	Binge Drinking [2]	Males having 5 or more drinks or females having 4 or more drinks on one occasion in the past 30 days.	15	44,528	13%	18	10	14	-	-	-	-	-	-
						Males higher		Racial/ethnic disparities could not be assessed due to small numbers						
	Heavy Drinking	Males having more than 2 drinks per day or females having more than 1 drink per day in the past month	5	16,352	-	5	4	5	-	-	-	-	-	-
						No difference		Racial/ethnic disparities could not be assessed due to small numbers						
Weight Status	Obesity	Body mass index of 30.0 of more. BMI considers weight in relation to height.	26	77,656	15%	27	26	27	19	-	-	-	-	-
						Males higher				Lower in Hispanic				
	Overweight & Obesity	Body mass index of 25.0 or more. BMI considers weight in relation to height.	64	189,290	-	71	55	64	51	42	-	70	75	47
						Males higher				Lower in Hispanic, Asian and Other				
Physical Activity and Nutrition	Leisure Time Physical Activity	Physical activity or exercise during the past 30 days other than on a regular job.	82	253,080	80%	84	81	83	70	80	-	81	65	69
						Females lower				Lower in Hispanic, Native American and Other				
	Recommended Level of Physical Activity [3]	Meet physical activity recommendations	54	153,267	50%	55	53	55	50	-	-	-	-	-
						No difference		Racial/ethnic disparities could not be assessed due to small numbers						
	Fruit and Vegetable Consumption [4]	Ate five daily servings of fruits and vegetables	26	77,401	-	18	33	25	-	-	-	-	-	-
						Males lower		Racial/ethnic disparities could not be assessed due to small numbers						
Emotional Health	Poor Emotional Health	Fourteen or more poor mental health days during a month.	10	30,227	-	8	12	10	-	-	-	-	-	-
						Females higher		Racial/ethnic disparities could not be assessed due to small numbers						
Chronic Illness	Asthma	Told by a doctor they currently have asthma	10	31,653	-	6	13	10	-	-	-	-	-	-
						Females higher		Racial/ethnic disparities could not be assessed due to small numbers						
	High Blood Pressure [3]	Told by a doctor they had high blood pressure	25	75,005	14%	25	23	25	-	-	-	-	-	-
						No difference		Racial/ethnic disparities could not be assessed due to small numbers						
	High Cholesterol [3]	Told by a doctor they had high cholesterol	35	81,891	17%	39	32	36	-	-	-	-	-	-
						Males higher		Racial/ethnic disparities could not be assessed due to small numbers						

Notes: see page 29. Red text: Worse rate Green Text: Better rate

	Health Conditions	Education (%)				Household Income (%)			Age (%)					
		Less than HS Grad	HS Grad or GED	Some College	College degree or more	<$25,000	$25,000 to $49,999	>$50,000	18 to 24	25 to 34	35 to 44	45 to 54	55 to 64	65+
Health Status	Health Status	74	83	88	93	71	87	94	94	91	89	85	84	78
			Increases with education				Increases with income				Decreases with age			
Health Access	Health Insurance	69	83	89	95	70	87	96	75	80	89	91	93	99
			Increases with education				Increases with income				Increases with age			
	Could Not Afford Doctor	29	16	13	6	30	15	5	19	16	15	12	7	4
			Decreases with education				Decreases with income				Decreases with age			
	Have Personal Doctor	58	72	78	83	65	75	83	58	63	77	80	89	95
			Increases with education				Increases with income				Increases with age			
	Dental Visit [1]	55	65	72	83	52	68	82	71	66	72	76	78	72
			Increases with education				Increases with income				Statisically significant but no identifiable trend			
Substance Use	Smoking	38	27	18	8	33	22	13	23	23	20	20	16	8
			Decreases with education				Decreases with income				Decreases with age			
	Binge Drinking	-	17	13	12	12	14	15	-	21	17	13	7	-
			Decreases with education				No statistical difference				Decreases with age			
	Heavy Drinking	-	5	4	4	4	5	5	-	-	4	5	4	3
			Decreases with education				No statistical difference				No statistical difference			
Weight Status	Obesity	27	28	30	21	32	28	24	15	29	27	30	31	23
			Decreases with education				Decreases with income				Statisically significant but no identifiable trend			
	Overweight & Obesity	61	62	66	61	61	66	64	39	63	65	70	72	63
			No consistent increase or decrease				No statistical difference				Statisically significant but no identifiable trend			
Physical Activity and Nutrition	Leisure Time Physical Activity	67	78	83	90	71	81	88	87	86	83	83	81	74
			Increases with education				Increases with income				Decreases with age			
	Recommended Level of Physical Activity	55	51	54	56	46	54	57	65	55	57	50	53	44
			No statistical difference				Increases with income				Decreases with age			
	Fruit and Vegetable Consumption		20	26	33	20	26	26	-	24	24	28	23	33
			Increases with education				No statistical difference				Increases with age			
Emotional Health	Poor Emotional Health	19	13	12	5	22	11	5	14	12	10	10	9	5
			Decreases with education				Decreases with income				Decreases with age			
Chronic Illness	Asthma	11	10	11	8	15	9	8	-	10	9	9	11	10
			No statistical difference				Decreases with income				No statistical difference			
	High Blood Pressure	24	27	24	22	30	27	21	-	10	13	26	42	57
			No statistical difference				Decreases with income				Increases with age			
	High Cholesterol	47	38	35	32	41	37	32	-	17	29	38	44	51
			Decreases with education				Decreases with income				Increases with age			

Notes: see page 29. Red text: Worse rate Green Text: Better rate

Youth Health Conditions and Behaviors

	Health Conditions	Definition	Clark County data: 2008 10th grade rate (%)	Clark County data: Clark County kids 12-17 in 2008	Clark County data: Healthy People 2010 Goal	Gender (%) 10th Grade Students: Male	Gender (%) 10th Grade Students: Female	Race/Ethnicity (%) 10th Grade Students: White	Hispanic	Asian	Native Hawaiian /Pacific Islander	Black	Native American	Other	>1 Race
Substance Use	Youth Smoking	Smoking in past 30 days	16	4,858	6% in grades 9-12	15	15	14	15	-	-	19	-	16	17
						No statistical difference		No statistical difference							
	Youth Alcohol Use	Alcohol use in past 30 days	30	9,566	-	31	31	30	38	21	37	34	37	31	35
						No statistical difference		Higher in Hispanic and >1 Race; Lower in Asian							
	Youth Marijuana Use	Marijuana use in past 30 days	19	5,566	-	19	15	16	20	-	-	26	-	18	22
						Higher in males		Higher in Hispanic, Black, and >1 Race							
	Youth Methamphetamine Use	Methamphetamine use in past 30 days	3	797	-	3	2	2	-	-	-	-	-	-	-
						Higher in males		Racial/ethic disparities could not be assessed due to small numbers							
Weight Status	Youth Overweight (top 5%)	Top 5% of BMI by age/gender	10	3,458	5% among teens 12-19	14	6	9	-	-	-	-	-	-	-
						Higher in males		Racial/ethic disparities could not be assessed due to small numbers							
	Youth Overweight and At Risk (top 15%)	Top 15% of BMI by age/gender	23	7,648	-	29	19	22	32	22	-	33	-	22	26
						Higher in males		Higher in Hispanic and Black							
Physical Activity and Nutrition	Youth Physical Activity [1]	Met physical activity recommendations of 60+ minutes five or more days in past week	44	13,476	-	50	35	42	40	38	-	43	-	38	42
						Lower in females		No statistical difference							
	Youth Fruit and Vegetable Consumption	Ate fruits and vegetables five or more times per day	25	7,982	-	24	21	21	26	25	-	-	-	31	26
						Lower in females		Higher in Other							
Emotional Health	Youth Poor Emotional Health	Felt so sad or hopeless almost every day for two consecutive weeks or more in a row during 12 months that they stopped doing some usual activites.	29	8,801	-	23	36	29	35	30	39	34	37	31	32
						Higher in females		Higher in Hispanic, Native Hawaiian/Pacific Islander, and Native American							
Chronic Illness	Youth Asthma	Told by doctor have asthma	20	6,776	-	20	20	19	19	-	-	-	-	23	21
						No statistical difference		No statistiical difference							

Infant Mortality

Health Conditions	Definition	County data: 2007 Rate per 1,00 live births	County data: 2007 Count	County data: Healthy People 2010 Goal	Gender: Male	Gender: Female	Race/Ethnicity: White	Hispanic	Asian	Native Hawaiian /Pacific Islander	Black	Native American	Other
Infant Mortality	Infant deaths per 1,000 live births	5	29	4.5 PER 1,000 LIVE BIRTHS	–	–	4	–	–	–	–	–	–
					Not assessed due to small numbers		Racial/ethic disparities could not be assessed due to small numbers						

Notes: see page 29. Red text: Worse rate Green Text: Better rate

Youth Health Conditions and Behaviors

	Health Conditions	Socioeconomic (%) Mother's Education: High School or less	Socioeconomic (%) Mother's Education: More than High School	Age%: 8th Grade	Age%: 10th Grade	Age%: 12th grade
Substance Use	Youth Smoking	19	11	7	15	21
		Decreases with mother's education			Increases with grade level	
	Youth Alcohol Use	36	28	16	31	41
		Decreases with mother's education			Increases with grade level	
	Youth Marijuana Use	21	14	7	17	21
		Decreases with mother's education			Increases with grade level	
	Youth Methamphetamine Use	3	2	1	3	2
		Decreases with mother's education			Increases with grade level	
Weight Status	Youth Overweight (top 5%)	12	8	10	10	11
		Decreases with mother's education			No statistical difference	
	Youth Overweight and At Risk (top 15%)	25	22	25	24	24
		Decreases with mother's education			No statistical difference	
Physical Activity and Nutrition	Youth Physical Activity	36	46	47	42	37
		Increases with mother's education			Decreases with grade level	
	Youth Fruit and Vegetable Consumption	20	25	28	23	20
		Increases with mother's education			Decreases with grade level	
Emotional Health	Youth Poor Emotional Health	35	26	26	30	28
		Decreases with mother's education			Increases with grade level	
Chronic Illness	Youth Asthma	22	20	19	20	21
		No statistical difference			No statistical difference	

Infant Mortality

Health Conditions	Socioeconomic: Mother's Education 2003-2007 rate per 1,000 live births: High School or less	Socioeconomic: Mother's Education 2003-2007 rate per 1,000 live births: More than High School	Age: Maternal age 2003-2007 rate per 1,000 live births: 15-19	20-24	25-34	35+
Infant Mortality	-	-	-	4	4	6
	Not assessed due to small numbers			No statistical difference		

Notes: see page 29. Red text: Worse rate Green Text: Better rate

Notes for Appendix A

Adult Health Conditions and Behaviors Notes: Race does not excludes Hispanic. 1 Data available for 2004, 2006 and 2008 only. 2 Data available for 2006, 2007 and 2008 only. 3 Data available for 2003, 2005 and 2007 only - data listed for County 2008 Rate/Count is from 2007. 4 Data available for 2005 and 2007 only - data listed for County 2008 Rate/Count is from 2007. Dash (-) is present when there is no applicable Healthy People goal or when data could not be displayed due to small numbers.

Technical notes: All disparity data are 2003 through 2008 combined unless otherwise noted. For all disparity groups other than race/ethnicity, disparities were identified based on the p-value (<0.05) even if confidence intervals overlapped. For race, if the p-value <0.05, disparity groups were identified if they were statistically significantly different than white (the referent group). For ethnicity, if the p-value <0.05, disparity groups were identified if they were statistically significantly different than non-Hispanic (the referent group). County estimates reflect the number of adults 18 years of age and older corresponding to a given rate.

Data Source: Washington State Department of Health. Behavioral risk factor surveillance system 2003-2008 [Data files]. Olympia, WA.

Youth Health Conditions and Behaviors Notes: Race excludes Hispanic 1Data available for 2006 and 2008 only. Dash (-) is present when there is no applicable Healthy People goal or when data could not be displayed due to small numbers.

Technical notes: All disparity data are 2004, 2006, and 2008 combined unless otherwise noted. For all disparity groups other than race and grade level, disparities were identified based on the p-value (<0.05) even if confidence intervals overlapped. For race, if the p-value <0.05, disparity groups were identified if they were statistically significantly different than white (the referent group). For grade, if the p-value <0.05, disparity groups were identified if they were statistically significantly different than 8th grade (the referent group). Count estimates were produced by averaging the 2008 prevalence in 8th, 10th, and 12th grades for each indicator and multiplying it by the number of children in the county aged 12-17 in Clark County in the 2000 Census.

Data Source: Washington State Department of Health. Healthy Youth Survey 2004, 2006, 2008 [Data files]. Olympia, WA.

Infanty Mortaily Notes: Race excludes Hispanic Dash (-) is present when data could not be displayed due to small numbers.

Technical notes: All disparity data are 2003 through 2007 combined unless otherwise noted. For all disparity groups other than race/ethnicity, disparities were identified based on the p-value (<0.05) even if confidence intervals overlapped. For race, if the p-value <0.05, disparity groups were identified if they were statistically significantly different than white (the referent group).

Data Source: Washington State Department of Health. Center for Health Statistics. Vital registration system, annual statistics files: Deaths 2003-2007 [Data]. Olympia, WA.

Appendix B Clark County Transportation Data

Modes of Transportation used in Commuting to Work

Clark County	1990	1990 Percent	2000	2000 Percent	2006	2006 Percent	2007	2007 Percent	2008	2008 Percent
Workers (16 years and over)	108,945		161,471		195,873		197,910		200,405	
Drive Alone	87,748	80.5%	128,014	79.3%	153,425	78.3%	156,350	79.8%	152,008	77.6%
Carpool	12,017	11.0%	18,089	11.2%	20,089	10.3%	20,058	10.2%	25,567	13.1%
Transit	2,275	2.1%	4,228	2.6%	4,944	2.5%	4,375	2.2%	4,272	2.2%
Walked	2,091	1.9%	2,211	1.4%	3,377	1.7%	3,114	1.6%	3,511	1.8%
Other	1,224	1.1%	1,788	1.1%	3,561	1.8%	2,685	1.4%	2,849	1.5%
Worked at Home	3,590	3.3%	7,141	4.4%	10,477	5.3%	11,328	5.8%	12,198	6.2
Mean Travel Time to Work (minutes)	21.2		24.7		25.1		25.2		24.7	

Data Source: US Census Bureau, American Factfinder, Decennial Census and American Community Survey [Data files].

Data Sources

Section 1: Economic Vitality, Employment and Income

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1.2 US Census Bureau, American FactFinder. 2008 American community survey 1-year estimates [Data files]. Retrieved from http://factfinder.census.gov/

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2.1 Educational Opportunities for Children and Families. Enrollment of Head Start and Early Head Start. Vancouver, WA.

2.2 University of Washington, Washington KIDS COUNT. Kids Count Data Center. Retreived from http://datacenter.kidscount.org/data/bystate/

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2.4 Washington State Department of Health. Behavioral risk factor surveillance system 2003-2008 [Data files]. Olympia, WA.

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Section 3: Active Transportation/Transportation Options

3.1 SW WA Regional Transportation Council. Vehicle Miles Traveled and C-Tran Boardings. Vancouver, WA.

3.2 Vancouver-Clark Parks and Recreation Department, Parks and Trails. Pathway User Counts Sept 8-12, 2009. Retrieved from http://www.cityofvancouver.us/parks-recreation/parks_trails/trails/index.htm

Section 4: Environment

4.1 Clark County Department of Assessment and GIS, Geographic Information System. Vancouver, WA.

Washington State Department of Ecology. Facility/Site Database [Data files]. Olympia, WA. Retrieved from http://www.ecy.wa.gov/fs/

Section 5: Accessibility of Food

5.1 Clark County Public Health. Grocery Store permits [Data files]. Vancouver, WA.

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Section 6: Social Environment: Connectedness and Exclusion

6.1 Clark County Neighborhood Outreach Program. Neighborhood Association affiliation. Vancouver, WA.

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US Department of Health and Human Services (2006). Healthy People 2010 Midcourse Review. Retrieved from http://www.healthypeople.gov/data/midcourse/

Adult: Washington State Department of Health. Behavioral risk factor surveillance system 2003-2008 [Data files]. Olympia, WA.

Youth: Washington State Department of Health. Healthy Youth Survey 2004, 2006, 2008 [Data files]. Olympia, WA.

Infant Mortality: Washington State Department of Health. Vital registration system, annual statistics file [Data files]. Olympia, WA.

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US Census Bureau, American FactFinder. American community survey 1-year estimates [Data files]. Retrieved from http://factfinder.census.gov/

US Census Bureau, American FactFinder. Decennial census [Data files]. Retrieved from http://factfinder.census.gov/

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